March 1, 2010

Neoconservativism and Health Care: Access and Equity for People who are Transgender, Two-Spirit, and Intersex

Jennifer Ajandi, Ontario Institute for Studies in Education

As feminist theorists, academics, practitioners, and activists, we are continuously learning, teaching, and advocating for social justice issues, particularly for marginalized populations. In this paper, I combine multiple perspectives of feminism to deconstruct systemic barriers for people who are transgender, two-spirit, and intersex. I explore policies and practices in the health care system that contribute to the exclusion of people who are transgender, two-spirit, and intersex. I also highlight underlying ideological and historical issues that face these populations within the current socio-political and medical context of North America. Particular emphasis will be placed on policies that are implemented in Canada. Attention will also be paid to the ways in which diverse gender identities were organized, respected, and revered before colonization. Theoretical frameworks used in this paper include anti-colonial, transgender, and intersexuality theories. There are multiple policies involved in the process of marginalization for people who are transgender. Some will be touched upon such as access to employment and the right to be free from violence. However, for the purpose of this paper I will mainly focus on the consequences of two policies: 1) The delisting of sex reassignment surgery in Ontario, Canada; and 2) The mandatory diagnosis of Gender Identity Disorder (GID) in order to obtain sex reassignment surgery. Key recommendations for policy development and implementation will also be highlighted.

Historical Context of Gender Ideology

Gender is seen largely as being socially constructed while the sex we are born into is seen as biological and fixed at birth. However, there is growing literature that examines gender being

fixed at birth as well (Fee, Brown and Laylor, 2003). While some people may feel their sex and gender are connected, or that both are fixed at birth, gender identity may operate more on a continuum, which can change depending on life experience, feelings, and spirituality.

Gender codes are based on restrictive categories of femininity and masculinity and are entrenched and embedded within our society; consequently, the experience of discrimination seems inescapable to people who do not conform to these codes. People who are transgender are made targets of negative value judgments and biases held by professionals, who are often the ones who are supposed to be working to support them. The transgender movement challenges society to expand its thinking about gender from operating only in dichotomous terms and instead to move in more fluid ways. The term transgender itself is used as an umbrella term that encompasses various gender identities spanning a continuum, including people who do not connect their physical body to society's prescribed gender characteristics (Feinberg, 1998; Stryker, 2008).

Literature explores the role of Aboriginal peoples in communities before colonization. Members of Aboriginal communities who express both genders or on a continuum may identify as two-spirit. The term two-spirit can be used to describe Aboriginal peoples' sexuality or their gender identity or a combination of both. Not everyone who is two-spirit would identify as being transgender in any way (Brotman, Ryan, Jalbert and Rowe, 2002). As settlers came to North America and colonized it, a particular socio-political framework guided them: a social order that is characterized by patriarchy and Christianity, incorporating a strict gendered hierarchy. Previously, two-spirit peoples were seen as spiritual leaders, possessing a gift of being sighted with both genders. The new culture belonging to people who colonized Canada did not include seeing two-spirit peoples in this positive way (Brown, 1997). Furthermore, two-spirit peoples

experience discrimination based on multiple and intersecting oppressions such as sexism, heterosexism, racism, and colonialism.

Sexism is an insidious form of structural oppression and is especially experienced by people who are transgender in Western cultures. Among other oppressions, sexism and heterosexism are interconnected. People who are transgender are often victims of violence and discrimination because of their perceived diverse sexualities. However, transphobia also involves forcing people to adhere to strict and categorized gender performance (Feinberg, 1998). Children learn from an early age through punishments and rewards that boys are supposed to express their gender identities through fixed categories typically associated with 'male' behaviour and girls are to express their gender identities typically associated with 'female' behaviour. When we restrict our sexual and gender identities to these stereotypical portrayals of masculinity and femininity, we perpetuate sexist ideologies and ignore the reality that gender expression occurs on a continuum, not as separate categories (Carroll, Gilroy and Ryan, 2002).

Intersexuality

It is beneficial to explore intersex identities when discussing how gender and sex are experienced on a continuum. Some gender-variant people who may identify as transgender are also (but not necessarily) intersex. The term intersex is used to describe people who are born with reproductive or sexual anatomy that does not fit what society considers typically male or female. This word has replaced the previous derogatory term hermaphrodite. As many as 4 percent of all births represent people who are intersex (Ontario Human Rights Commission, 2000). Sometimes babies are born with visible differences while others may not notice these differences until they reach puberty or later in life. Others have lived their whole lives as intersex and this identity is not discovered until after they have died and is revealed through autopsies

(Intersex Society of North America, 2009).

The general "treatment of care" prescribed by medical associations when babies present as intersex is to assign a gender and sex at birth in order to achieve what is believed to be "normal" (Butler, 2004; Feinberg, 1998; Stryker, 2008). The ideology behind assigning a gender at birth has been largely informed by Dr. John Money of Johns Hopkins University. In the 1950s Dr. Money and his colleagues developed a set of guidelines on how to treat intersex children. The treatment was intended to be pragmatic and focused on maximizing the patients' reproductive and sexual function, normalizing appearance, and assigning a stable gender identity. Immediately after birth, a sex would be assigned through surgery and hormone therapy. These guidelines are still widely used today across North America (Kessler, 1998).

Dr. Money believed immediate 'corrective surgery' was needed before the age of 18 months. He proposed that during this time period in an infant's life, gender identity was malleable and socialization alone would determine the gender of the child. As long as parents and others raised children in a consistent fashion, children would believe themselves to be the assigned gender. This approach emphasized strict, binary gender roles by using typical boy- and girl-coloured clothing, "gender appropriate" toys, and gendered recreational activities. It was important for the parents to show no sign of ambiguity concerning the child's sex. Dr. Money used his own patients from his research and came to the conclusion that the strongest influence on a child's identity is how the child is raised (Blizzard, 2002). However, there have been many critiques of the legitimacy of his conclusions, including unethical practices of forcing sexual images and acts upon his patients in order to conform to the expectations of the assigned gender (Butler, 2004).

Dr. Money's findings became known as the theory of gender neutrality (Fausto-Sterling,

2000). While socialization plays a strong role in gender identity, using a dogmatic approach that illustrates only one perspective when analyzing the influences of gender identities is problematic. Discounting other influences, such as biology and the innate intuition that people feel with regard to their identities, in effect renders these influences invisible. Solely focusing on socialization as the overall "reason" for gender identity could lead to arguments that blame parents, most often the mother, for raising children with gender- and sex-variant identities. Furthermore, focusing on a root "cause" or "condition" surrounding sex or gender identities frames the discourse in such a way that problematizes and pathologizes these identities. We do not ask what it is that makes or 'turns' people heterosexual and male or female. These questions are asked only when it is an identity that does not fit into normalized thought. Gender and sex are compartmentalized into dichotomous and gendered categories and anything that falls outside of these parameters is seen as 'abnormal'.

Some patients, whom Dr. Money documented as having successful reassignment surgeries, have since rejected their assigned sex. Many of the patients categorized as successfully reassigned are still troubled by the aftermath of surgery. They have reported genital scarring that greatly reduces sensitivity and the surgery often has to be repeated during adolescence even though there is no data on the long-term implications of the surgeries (Blizzard, 2002).

Dr. Money's analysis failed to account for how culture is an agent of socialization. There are significant differences among cultures pertaining to sex and gender expressions. Typical 'gender markers' known throughout Westernized cultures are not universal. Many diverse gender performances exist and include men wearing dresses, men showing affection with each other, and women occupying 'masculine' professions or heading entire households. A broad and sweeping diagnosis for a child who is intersex cannot be made without taking numerous cultural

perspectives into account. Ignoring all of these relevant factors only leads to further isolation and confusion felt by the child.

The Intersex Society of North America (ISNA) is an organization that advocates on behalf of people who are intersex. Cheryl Chase is the founder of the ISNA and has undergone a complete clitorectomy. This procedure is performed less frequently on people who are intersex today, but scarring and loss of sensitivity still occur with many of the procedures performed.

The ISNA disagrees with the current practice of immediate surgery on infants. Currently, doctors inform parents of this surgery and encourage them to provide consent. The ISNA advocates for parents and doctors to delay this decision until children are old enough to participate in the decision-making process. The ISNA recommends a Patient-Centered Model of care whereby children are treated without shame and secrecy. It is important that all files, records, and information are handled in an honest and transparent way. Parents and children are encouraged to connect to peer support groups outside of the clinical setting to share their stories with each other with an aim to decrease isolation and normalize their experiences. The ISNA recommends surgery only in cases where it is life threatening. Surgeries that are suggested to 'normalize' the appearance of genitals should only be done when the child is mature enough to make an informed decision.

The ISNA is critical of the standard of care for intersex children developed by the medical specialists at Johns Hopkins University in the 1950s. Heterosexist protocols are in place in order to get the gender assignment settled early on so that children will be "good heterosexual" girls and boys. Sexism and heterosexism can intersect in people's identities; it is difficult to separate where one oppression begins and the other one ends. Queer theory is useful in this analysis by deconstructing fixed categories and lending itself to more fluid notions of

identity and how they relate to each other. When I refer to "queer," I view it as an analytic and political framework that represents "a complex and changing identity, where people locate themselves in different places at different times" (Peters, 2005, p. 102).

The guidelines that are used by the medical profession for babies born intersex contain arbitrary, heterosexist and sexist categories. The American Paediatrics Association clearly lists the requirements and guidelines, which include treating babies who are thought to be girls differently from babies who are thought to be boys. The main concern with regard to surgery for babies thought to be girls is the preservation of fertility (assuming heterosexual reproduction), giving no attention or importance to sexual sensation. For babies thought to be boys, the primary concern is size and function of the penis. Under the gender-rearing model, boys born with penises doctors thought to be too small were made into girls even though there is evidence that these boys could be raised as boys without castration, genital surgery and hormone replacement. Boys who were considered not able to grow up to be "real men" by societal standards were surgically altered and assigned the female sex. Babies thought to be girls who doctors decide have clitorises that are too big are still surgically reduced even though it is healthy tissue and performing this surgery actually reduces sensation (Intersex Society of North America, 2009).

These are explicit examples of how life-altering decisions are made on people, without their consent, and the underlying implicit heterosexist and sexist values and assumptions that guide them. Parents technically have a say in the decision making process; however, the medical profession is normalized as being an objective, scientific, and unquestionable body of knowledge. Therefore, doctors are in a position of power to influence parents' decisions. Rarely do we think of questioning such perceived expert knowledge because parents are not empowered in the health-care setting to even ask questions, let alone challenge a proposed treatment plan and

the assumptions regarding what is normal and healthy.

Access to Services for People who are Transgender and Two-Spirit

True access to social services is restricted through administrative measures. Most social services facilities are gendered and only allow service users to identify as female or male (sex assigned at birth) categories. For example, in the violence-against-women sector, most shelters are conceptualized as women-only spaces. These spaces either directly refuse access to women who are transgender or have not done the organizational work needed to become a transgender-inclusive space such as providing educational workshops on an ongoing basis, doing a needs assessment in the community to find out what supports women who are transgender identify, or demonstrating representation by hiring staff who identify as transgender. When women-only spaces do not provide true access for transgender women, it puts them at an increased risk for sexual and physical violence because they are left with entering male-only spaces such as traditional shelters for men (Namaste, 2005). There needs to be a safe and private space provided for people in social service agencies and health care settings who express various gender identities but also create an opportunity where they can integrate with others, depending on their preference.

There are many administrative barriers that exist for people who do not fit into typical biological categories. Administrative forms need to include boxes that are not restricted to just male and female or man or woman. Forms should include a variety of identities such as transgender, transsexual, two-spirit, and intersex, or should provide an open-ended space for people to self-identify their sex and gender. Administrative barriers also include only offering services based on legal identity. Restrictions have increased in regard to changing names since the events of 911 and changing the sex-at-birth section on a birth certificate (which is restricted

to male and female) is even more difficult. People must undergo full sex-reassignment surgeries before they are permitted to change their names. The financial cost of even the most basic administrative paperwork is often too high for many people who experience poverty and are transgender. What is even more confusing is in Ontario, Canada, there are no coordinated protocols as administrative processes are governed by both municipal and provincial powers. Navigating the administrative terrain becomes even more complicated for people who are transgender and especially for recent immigrants or refugees. People without status are especially vulnerable to racism. Unfortunately, there is a scarcity of research that examines the intersections of identities such as transgender, non-status, and/or newcomer.

Sex Reassignment Surgery

A key policy/procedure that will improve the conditions of peoples' lives who are transgender is reinstating sex reassignment surgery (SRS) under the Ontario Health Insurance Plan (OHIP). One of the first steps the Harris Conservative government took when elected in 1995 was to reduce or completely eliminate funding for services directed towards women and children (Lightman and Baines, 1996). The neo-conservative ideology surrounding the government's funding decisions promoted the traditional nuclear family structure. Identities other than White, male, heterosexual, and able-bodied were seen as the 'Other'. The Harris government targeted specific policies that denied the 'other' allocations of resources while privileging the 'norm' (Lightman and Baines, 1996). This conservative policy agenda has similarities to ones around the world that emphasize a free market and privatize needed social supports.

In 1998, SRS was officially cut from the list of services that is provided under OHIP. Due to marginalization, many people who are transgender face extreme levels of poverty. It is rare for

someone to be able to afford SRS without health insurance. The Conservative government sent a message through this funding cut that people who are transgender and issues specific to them are not to be valued, respected and deemed as important (Ontario Human Rights Commission, 2000). Previous to this, SRS had been insured since 1970 under the approval of the Clarke Institute of Psychiatry.

The Honourable George Smitherman, Minister of Health and Long Term Care for Ontario, continuously attempts to reinstate funding for SRS; however, some other Liberal MP's have blocked this effort. The reason given when the Conservatives made the cut and the reason the Liberals are not reinstating it is the same – both parties claim that the province cannot afford it. This is a troublesome response considering SRS only costs OHIP an average of $150,000 per year (Torchlight Gender Support, 2005). There is also an issue of long-term costs that the government is not taking into consideration. The consequences of not covering the surgery may include an increase in costs directed towards counseling. Not insuring SRS also affects the health- care system because it may contribute to an elevated risk of suicide for people in the transgender community (Ontario Human Rights Commission, 2000).

The medical profession believes that transgender issues should not be seen as a political movement. These issues are to be resolved within the medical and psychiatric communities. Shortly after 'homosexuality' was removed from the Diagnostic and Statistical Manual in 1973 (Stryker, 2008), Gender Identity Disorder (GID) was added. It is through this diagnosis as a psychiatric disability that people who are transgender can receive treatment. This is highly controversial because many people who are transgender do not conceptualize their identity as a pathology or a disability.

Gender Identity Clinics emerged in the 1960s in response to people who were transsexual

and demanded access to hormones and sex reassignment surgeries. In Ontario, the Gender Identity Clinic began in 1969 at the Clarke Institute of Psychiatry in Toronto as a pilot program with the University of Toronto. Dr. Harry Benjamin created the Standards of Care, which act as guidelines that are used by gender clinics and physicians across North America and Europe. These Standards of Care involve intensive psychotherapy and hormone therapy (Stryker, 2008). These are not 'law' in psychiatry; however, most surgeons performing SRS insist on patients meeting these criteria (Kessler, 1998).

The Real Life Test/Experience

The Real Life Test, now called the Real Life Experience (RLE), is highlighted as the first 'gate-keeping' mechanism used in Harry Benjamin's Standards of Care. It requires people who want to transition to live in their desired sex for one year 'as proof' of their commitment prior to having access to the benefits of body-altering surgeries. Hormones and surgeries are needed to facilitate a transsexual man or woman to live and pass safely in society. The underlying assumptions in this policy reflect the thought that medical staff are experts and gatekeepers of people's life choices. Patients are also infantilized through the notion that they do not know their own bodies and identities. For people who are transgender to live in a sex different from the one assigned at birth, it requires basic administrative changes such as changing the sex and or name on birth certificates or drivers licenses. However, a certified letter confirming a person has received SRS is required in order to attain these changes (Bowman and Goldberg, 2006).

The reason cited for health-care professionals insisting on enforcing the RLE is because of the fear patients will regret their surgeries. However, studies that have researched 'persistent regret' among patients found that transsexuals experienced less regret about their transition surgeries than did the general population (Bowman and Goldberg, 2006). Implementing specific

and stringent guidelines surrounding the choice to surgically transition is representative of larger paternalistic and biodeterministic analyses often found in the health-care system.

Barriers to Health Care

Transphobia permeates the medical model of health. The medical model pathologizes gender identities and bodies into dichotomous categories of normal and abnormal. People who are transgender experience transphobia through misdiagnosis by mental health professionals when they are treated as medically ill and are prescribed adverse treatments such as aversion therapies, which enforce gender normative behaviours. People who are transgender report that the primary reason they do not access health-care services is because of the insensitivity of health-care providers (Bowman and Goldberg, 2006). There are physicians who will not take people who are transgender as patients and some who do will refuse to perform full physicals. Feinberg (1998), who uses the term "hir" as a rejection of the binary language 'her' or 'his' discusses hir experience of being discriminated against in a hospital emergency room. After learning of hir transgender identity, the doctor replies, "You have a fever because you are a very troubled person" (Feinberg, 1998, p.2).

There are assumptions made by people in the health care system that issues of access for people who are transgender should focus on only hormones and sex reassignment surgery; however, most people cannot financially afford to transition. Sex-reassignment surgery costs between $17,000 and $27,000. This is an enormous economic barrier. It is important to focus more broadly on barriers to health care by looking at critical social determinants of health perspectives, which would take into account access to employment, education, and housing, among other things (Maguen, Shipherd and Harris, 2005). Acknowledging how race, class, gender identity, and ability intersect with social determinants of health is important to

understanding the complexity of institutional barriers.

It would be naïve to suggest there are only one or two key policies that need to be improved in order to systemically improve the conditions for people who are transgender. For the purpose of this paper I focused on and highlighted the delisting of SRS in Ontario from OHIP as one important barrier. True access to health care should be the right of every person. The right to accessible health care is especially important for people who are transgender, two-spirit, and intersex because of the high levels of discrimination they experience.

Barriers to Employment

In order to address the poverty experienced by people who are transgender, barriers to employment must be remedied. People who are transgender experience individual discrimination by employers, colleagues and customers. In one study, people who are transgender faced explicit discrimination by not being permitted to use the washroom and more subtle forms such as having colleagues talk behind their backs. Sometimes after transitioning they lost their jobs. However, it was difficult to address this discrimination because they were told things such as "you were not living up to our standards" (Maguen, Shipherd and Harris, 2005, p. 486). If people who are transgender are in the process of finding employment but have just transitioned, it can be difficult because their official documents and reference letters may be addressed to their previous names. For people who have not yet transitioned, they are pressured and coerced into dressing and acting in ways that conform to notions of socially prescribed gender roles.

Sex work is a type of employment that some people who are transgender take up, in part, because of the discrimination in the paid labour force. Unfortunately, health promotion materials rarely target sex workers and therefore put them at higher risk for health issues. The criminalization of sex work means there is no protection for workers, health coverage, benefits,

employment insurance, or health and safety precautions. Moreover, workers are often charged and sent to prison. Commonly held negative attitudes towards sex work means that violence and harassment may go unnoticed or seen as justified by police. However, there are also many benefits to sex work, including decent wages as opposed to no wages and access to communities where transgender, transsexual, and two-spirit peoples can connect with others. Sex work can also offer validation to some people who are transgender, emphasizing how their bodies are beautiful and desirable in a society that treats them as undesirable. Many people who are transgender resent social services that aim to 'save' them from the streets and instead want to have services support them in their work (Namaste, 2005).

Anti-Transgender Violence

According to the Gender, Violence and Resource Access Survey, 50% of respondents had been raped or assaulted by a romantic or intimate partner. Transgender and two-spirit peoples who do pass as either male or female may be outed if they attempt to escape an abusive relationship. Family members may emotionally, physically and sexually assault children and youth who are atypically gendered according to societal expectations (Bonvillain, 2000). Many transgender people face violence, discrimination and hate on a daily basis. The most extreme expression of this hate is through murder, which often goes unsolved. Oftentimes hate crimes are committed against people who are transgender by family members or intimate partners.

People who are transgender are made targets of negative value judgments and biases that are held by professionals who are supposed to be sources of support. These professionals include social workers, employers, landlords, teachers, health care providers, and police officers. Many people in the transgender community feel particularly threatened by the police because of direct harassment, discrimination, and/or a refusal to investigate or take complaints of violence against

them seriously. It is no wonder that people who are transgender feel abandoned by a culture that sits back and allows them to experience abuse alone and without protection (Cochran, Stewart, Ginzler, and Cauce, 2002).

Policy Recommendations to Improve Access

One policy recommendation I make focuses on conceptualizing and actualizing the right to transition as a human-rights issue. It is crucial for SRS to be a reinsured medical surgery. For some people who are transgender, the first aspect of their lives that needs to be addressed is the right to transition, which helps to reconcile their bodies with their identity expressions. A second policy recommendation is that gender identity needs to be recognized as a self-identified category, especially in administrative circumstances. Providing a space where people can self identify instead of conforming to either checking the 'male' box or 'female' box is needed.

In a broader context, we need to examine the underlying ideologies and assumptions regarding gender identity. The expression of gender identity needs to be seen on a continuum instead of in fixed and normalized categories. Challenging dominant gender norms and expectations is beneficial to all of society as it fosters an environment where people can feel free to dress, behave and work in ways that do not require external rewards and punishments based on strict adherence to gender norms (Feinberg, 1998).

Specific health issues for people who are transgender need to be incorporated in health care professionals' curriculum. Consistent and mandatory training in the workplace on how to meet the needs of people who are transgender also should be implemented. In Ontario, Canada, SRS is currently not covered through OHIP. Because of discrimination in society and barriers to basic necessities, people who are transgender, two-spirit, and intersex are placed at an increased risk for violence, homelessness and poverty, demonstrating how access to health care services

are important for survival.

References

Blizzard, R.M. (2002). Intersex Issues: A Series of Continuing Conundrums, Pediatrics, 110, 616-621.

Bonvillain, N. (2000). A Third Gender in Women and Men: Cultural Constructs of Gender. New Jersey: Prentice Hall.

Bowman, C. and Goldberg, J. (2006). Care of the patient undergoing sex reassignment surgery (SRS). Vancouver Coastal Health, Transcend Transgender Support and Education Society and the Canadian Rainbow Health Coalition. http://www.vch.ca/transhealth/resources/library/tcpdocs/guidelines-surgery.pdf

Brotman, S, Ryan, B., Jalbert, Y., and Rowe, B. (2002). Reclaiming space regaining health: The health care experiences of two-spirited people in Canada. Journal of Gay and Lesbian Social Services: Issues in Practice, Policy and Research, 14, 1, pp. 67-87.

Brown, L.B. (1997). Women and men, not-men and not-women, lesbians and gays: American Indian Gender Style Alternatives. Journal of Gay and Lesbian Social Services, 6(2), 5-20.

Butler, J. (2004). Undoing Gender. New York: Routledge.

Carroll, L, Gilroy, P.J., and Ryan, J. (2002). Counselling transgendered, transsexual, and gender-ariant clients. Journal of Counselling and Development, 80(2), 131-142.

Cochran, B.N., Stewart, A.J., Ginzler, J.A., and Cauce, A.M. (2002). Challenges faced by homeless sexual minorities: Comparison of gay, lesbian, bisexual, and transgender homeless adolescents with their heterosexual counterparts. American Journal of Public Health, 92(5), 773-777).

Fausto-Sterling, A. (2000). The Five Sexes, Revisited. Sciences, 40, 18-24.

Fee, Brown, and Laylor. (2003). One size does not fit all in the transgender community. American Journal of Public Health, 93(6), 899-901.

Feinberg, L. (1998). Trans Liberation: Beyond Pink or Blue. Boston: Beacon Press.

Heyes, C.J. (2003). Feminist solidarity after queer theory: The case of transgender. Signs: Journal of Women in Culture and Society, 28(4), 1093-1122.

Intersex Society of North America (ISNA). (2009). Available online http://www.isna.org.

Kessler, S.J. (1998). Lessons from the Intersexed. New Jersey: Rutgers University Press.

Lightman, E. and Baines, D. (1996). White men in blue suits: Women's policy in conservative Ontario. Canadian Review of Social Policy, 38, 145-152.

Maguen, S. Shipherd, J.C. and Harris, H.N. (2005). Providing culturally sensitive care for transgender patients. Cognitive and Behavioral Practice, 12(4), 479-490.

Namaste, V. (2005). Sex Change, Social Change: Reflections on Identity, Institutions, and Imperialism. Toronto: Women's Press.

Ontario Human Rights Commission. (2000). Towards a commission policy on gender identity. Available online http://www.ohrc.on.ca/english/publications/gender-identity-policy.shtml.

Peters, W. (2005). Queer identities: Rupturing identity categories and negotiating meanings of queer. Canadian Woman Studies, 24(2/3), 102-108.

Stryker, S. (2008). Transgender History. Berkeley, California: Seal Press.

Torchlight Gender Support. (2005). The Liberals. Available online http://home.golden.net/~kcr/tgs/index.html?main=Liberals2.html.